Chapter 16 Pre Test

Smith,Crystal

Submitted: 5/2/2011 4:45:51 PM **Grade:** 29.2% **Attempt Number:** 1/3 **Questions Attempted:** 24/24

1. **Which of the following statements made by the daughter of a client with schizophrenia reflects an understanding of the genetic theory of schizophrenia?**
   a. "People with schizophrenia inherit the disease from a mutated gene."
   b. "People with schizophrenia inherit a genetic predisposition to the disease rather than the disease itself."
   c. "People with schizophrenia can be identified by the presence of CGEMS."
   d. "GenoProof® has identified the genetic marker for schizophrenia."

   Grade: 0
   User Responses: d."GenoProof® has identified the genetic marker for schizophrenia."
   Feedback: a.Rationale: To date, no specific genetic maker for schizophrenia has been found. CGEMS is the acronym for the cancer genetic markers of susceptibility.
   Cognitive Level: Evaluation
   Nursing Process: Evaluation
   Client Need: Psychosocial Integrity

2. **The family of a client with schizophrenia asks the nurse if schizophrenia is caused by "something in the blood". The nurse explains that symptoms may be related to overactive neuronal activity that is dependent on a neurotransmitter called:**
   a. Myelin.
   b. Vasopressin.
   c. Dopamine.
   d. Peptides.

   Grade: 0
   User Responses: d.Peptides.
   Feedback: a.Rationale: The dopamine hypothesis states that symptoms are associated with excessive dopamine transmission. Peptides, such as vasopressin, are compounds composed of two or more amino acids. Myelin is a component of the myelin sheath which serves as insulation to increase the rate of transmission of signals. Vasopressin is an amino acid peptide, commonly known as the antidiuretic hormone, which is active in conserving water in the body by reducing water loss in the urine.
   Cognitive Level: Application
   Nursing Process: Implementation
   Client Need: Psychosocial Integrity

3. **The nurse is completing a family history on a client with schizophrenia. The client has an identical twin, adopted by another family, who is "normal." This finding lends support to which of the following biopsychosocial theories of schizophrenia?**
   a. Genetic
   b. Environmental
   c. Neurological
   d. Biochemical

Grade: 0
User Responses: d.Biochemical
Feedback: a.Rationale: The data provided lends support to the influence of environment on the incidence of schizophrenia. The fact that both twins are not affected when they are genetically identical indicates that environment plays a large part in the expression of the illness. At the present time there is no known specific genetic or biochemical marker for schizophrenia, nor is there a known specific neurological indicator.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

4. **During admission to the inpatient mental health unit, a client tells the nurse he hears voices that "tell" him he "is a worthless human being". The nurse correctly documents the client's symptoms as:**
   a. Sensory overload.
   b. Schizophrenic behavior.
   c. Disorganized speech.
   d. Hallucinations.

Grade: 1
User Responses: d.Hallucinations.
Feedback: a.Rationale: The client is experiencing auditory hallucinations which are the most common perceptual disturbances in schizophrenia. Disorganized speed would manifest as the inability or difficulty communicating a complete sentence. Schizophrenia is an illness, not a form of behavior. Sensory overload may contribute to hallucinations, but is not a symptom seen in the client with schizophrenia.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

5. **The husband of a client reports to the nurse that his wife "just doesn't seem to enjoy doing anything or being around anyone". The client's husband is describing a symptom often seen in clients with schizophrenia known as:**
   a. Isolation.
   b. Alopecia.
   c. Anhedonia.
   d. Avolition.

Grade: 0
User Responses: d.Avolition.
Feedback: a.Rationale: Anhedonia is the inability to experience pleasure. People with schizophrenia cannot enjoy experiences because of the physiologic reason over which they have no control. Alopecia is loss of hair and is not related to schizophrenia. The client with schizophrenia may prefer isolation as opposed to being with others; however, this is not the characteristic described by this client's husband. Avolition is a symptom evidenced by inability to pursue and persist in goal-directed activities.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Physiological Integrity

6. **During group, the nurse observes that when a client with schizophrenia responds to his peers, he responds using one or two words as opposed to a complete sentence. Which of the following behaviors is descriptive of this client's speech?**
   a. Flight of ideas
   b. Flat affect
   c. Alogia
   d. Isolation

Grade: 0
User Responses: d.Isolation
Feedback: a.Rationale: The client's brief verbal responses are known as alogia. Alogia, the poverty of speech, is thought to be symptomatic of diminished thoughts and is different from a refusal to speak. A flat affect refers to the client's overall emotional tone as opposed to a pattern of speech. Flight of ideas occurs when the client jumps from topic to topic during a conversation. Isolation is not a description related to speech.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychological Integrity

7. **A client's brother tells the nurse that the client has the "worst type" of schizophrenia. Which of the following responses made by the nurse would validate the brother's statement? "I am understanding you to say your bother has:**
   a. Disorganized schizophrenia."
   b. A schizoaffective disorder."
   c. Undifferentiated schizophrenia."
   d. A delusional disorder."

Grade: 0
User Responses: d.A delusional disorder."
Feedback: a.Rationale: Disorganized schizophrenia is recognized as the most severe subtype of schizophrenia. Undifferentiated schizophrenia may be diagnosed when the client is in an active psychotic state, but does not have prominent sypmtoms that match any of the subtypes. Schizoaffective disorder may be present when two sets of symptoms (schizophrenia and a mood disorder) occur concurrently in the same illness episode. Delusional thinking may or may not be present in a client with schizophrenia, but schizophrenia is not categorized as a delusional disorder.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychological Integrity

8. **A client believes someone is coming into the house and stealing all the jewelry. Which of the following types of schizophrenia is often associated with delusional thinking?**
   a. Affective
   b. Paranoid
   c. Catatonic
   d. Alzheimer's

Grade: 0
User Responses: d.Alzheimer's
Feedback: a.Rationale: Persecutory delusions present in the client with paranoid schizophrenia.The client with catatonic schizophrenia experiences some type of extreme psychomotor disruption. Affective problems are associated with mood disorders. Alzheimer's is associated with dementia.
Cognitive Level: Analysis
NursingProcess: Assessment
Client Need: Psycosocial Integrity

9. **Which of the following nursing diagnoses are applicable when developing a plan of care for the client with catatonic schizophrenia in a state of waxy flexibility? (Select all that apply.)**
   a. Health maintenance, ineffective
   b. Nutrition, imbalanced
   c. Mobility, impaired
   d. Disuse syndrome
   e. Injury, risk for

Grade: 0
User Responses: e.Injury, risk for
Feedback: a.Rationale:
Nutrition, imbalanced. The client with schizophrenia in a catatonic state is at risk for imbalanced nutrition and may need prompting or feeding.

Mobility, impaired. The client with schizophrenia in a catatonic state is at risk for impaired mobility due to remaining immobile for long periods of time.

Health maintenance, ineffective. Ineffective health maintenance refers to the individual's lifestyle as opposed to behaviors related to a disorder.

Disuse syndrome. Disuse syndrome is appropriate for the client who has lost functional ability.

Injury, risk for. The client with schizophrenia in a catatonic state is at risk for injury due to lack of awareness of the environment.

Cognitive Level: Synthesis
Nursing Process: Planning
Client Need: Safe, Effective Care Environment

10. **A client with schizophrenia is admitted to the inpatient mental health unit. The client suddenly runs into the day room, picks up a chair and throws it at the staff. Which of the following interventions would the nurse attempt first?**
    a. Threaten to restrain unless the client acts appropriately.
    b. Approach in a calm manner and escort the client to his/her room.
    c. Provide an activity to redirect the client's energy.
    d. Enlist additional staff to assist, if needed.

Grade: 1
User Responses: d.Enlist additional staff to assist, if needed.
Feedback: a.Rationale: The nurse would first enlist additional staff to assist, if needed. The nurse must anticipate the safety needs of self and others. When the nurse approaches the client, it should be done in a calm manner, but this would not be the first action. The client may need to be escorted to the client's room, away from the common area, but this would not be the first action. The client may be amenable to redirection; but this would not be the first action in this situation. Threatening a client is never a therapeutic intervention.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Safe, Effective Care Environment

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11. **Which of the following nurisng diagnoses would specifically relate to the client with delusions of grandeur?**
    a. Social isolation
    b. Low self-esteem
    c. Ineffective coping
    d. Disturbed thought processes

    Grade: 1
    User Responses: d.Disturbed thought processes
    Feedback: a.Rationale: The client with delusions of grandeur is experiencing impaired thought processes; therefore, the specific diagnosis is disturbed thought processes. There is no evidence to suggest the client is experiencing social isolation or low self-esteem or how the client is coping.
    Cognitive Level: Synthesis
    Nursing Process: Planning
    Client Need: Psychosocial Integrity

12. **The nurse is working with a family of a client recently diagnosed with schizophrenia. Which of the following statements indicates a need for further family education?**
    a. “The medicine will cure his symptoms.”
    b. “We will encourage him to take his medicine.”
    c. “We will make sure he takes his medication.”
    d. “The medicine may cause side effects.”

    Grade: 0
    User Responses: d.“The medicine may cause side effects.”
    Feedback: a.Rationale: At this point in time, medications help with symptom management but are not curative, thus a response by the family member about curing symptoms indicates a need for further education about the illness. It is important that the client take his medication. It is possible the client may not experience any side effects from the medication, but clients often experience some form of side effects, such as dry mouth. Ideally, the client will be responsive to encouragement to taking the medication, but the family may need to monitor compliance.
    Cognitive Level: Evaluation
    Nursing Process: Evaluation
    Client Need: Psychosocial Integrity

13. **Which of the following characteristics of the nurse will interfere with the therapeutic nurse-client relationship?**
    a. Integrates cultural sensitivity
    b. Engages in introspection
    c. Demonstrates decreased self-awareness
    d. Demonstrates acceptance of individual differences

Grade: 0
User Responses: d.Demonstrates acceptance of individual differences
Feedback: a.Rationale: Self-awareness is a prerequisite for engaging in therapeutic interpersonal communication. With decreased self-awareness the nurse will not be cognizant of his/her nonverbal communication. Accepting individual differences is essential to the therapeutic nurse-client relationship. Integrating cultural sensitivity enhances the therapeutic nurse-client relationship. Engaging in introspection is necessary for self-awareness. With decreased self-awareness the nurse will not be aware of how others react to his/her actions.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Psychosocial Integrity

14. **During nursing report, the nurses are discussing ways to prompt a client to participate in milieu activities. Which of the following responses would be least likely to facilitate this goal?**
    a. Assisting the client with selecting several groups to attend.
    b. Praise the client for attending group.
    c. Provide incentives for the client to attend group.
    d. Inform the client that he will not be permitted to have supper if he doesn't go to group.

Grade: 1
User Responses: d.Inform the client that he will not be permitted to have supper if he doesn't go to group.
Feedback: a.Rationale: Informing the client that he will not be permitted to have supper if he doesn't go to group is a threat to the client and is not an acceptable option. Praising the client for attending group serves to enhance self-esteem by acknowledging the client's presence and worth. Providing incentives for the client to attend group will also enhance self-esteem by providing the client with an opportunity to earn a reward. The client may have difficulty making a selection from several choices of groups, so assisting the client in making a selection is an acceptable intervention.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Psychosocial Integrity

15. **A treatment facility housekeeper is overheard making the following statement: "I don't understand why schizophrenics are so messy." Which of the following corrective actions is indicated?**
    a. In-service staff on behaviors associated with thought disorders.
    b. Transfer the housekeeper to another area.
    c. No action is needed.
    d. Reprimand the housekeeper for being unprofessional.

Grade: 0
User Responses: d.Reprimand the housekeeper for being unprofessional.
Feedback: a.Rationale: Corrective action would be to in-service staff on behaviors associated with thought disorders. This would serve to assist staff in understanding the needs of clients to help maintain a therapeutic milieu. Reprimanding the housekeeper or transferring the housekeeper to another area do not reflect corrective actions. Failing to take action is a passive response which is counterproductive to empowering staff with knowledge needed to understand client needs, regardless of their responsibility.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Safe, Effective Care Environment

16. **Which of the following interventions would assist the family with minimizing the potential for relapse in a family member with schizophrenia?**
    a. Limiting choices for taking medication
    b. Providing tangible rewards
    c. Providing illness education and support
    d. Helping the family understand the purpose of hospitalization

Grade: 0
User Responses: d.Helping the family understand the purpose of hospitalization
Feedback: a.Rationale: Educating the family about the illness and providing support will assist the family in early recognition of symptoms of a relapse and in seeking support to prevent a relapse. Limiting choices for taking medication, providing the client with tangible rewards, and helping the family understand the purpose of hospitalization are interventions to promote patient compliance and are components of illness education and support.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Psychosocial Integrity

17. **An independent nursing intervention found to be effective in delaying or preventing relapse is:**
    a. Referring client for case management.
    b. Modifying maintenance medication.
    c. Ignoring maladaptive behavior.
    d. Intervening when prodromal symptoms occur.

Grade: 1
User Responses: d.Intervening when prodromal symptoms occur.
Feedback: a.Rationale: Close monitoring for prodromal symptoms enables early clinical intervention, which may prevent a relapse. Modifying a client's maintenance medication is not an independent nursing intervention. Maladaptive behavior will require redirection or closer supervision. Referring a client for case management is a collaborative intervention made by the treatment team.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Safe, Effective Care Environment

18. **Measures to prevent relapse, in addition to pharmacology, include:**
    a. Institutionalization.
    b. Cognitive-behavioral therapy.
    c. Hospitalization.
    d. Electroconvulsive therapy.

Grade: 0
User Responses: d.Electroconvulsive therapy.
Feedback: a.Rationale: Cognitive-behavioral therapy is used with clients who have thought disorders to help them learn to deal with negative harmful thoughts and to help them develop alternatives that are more positive, focused, and goal directed. Hospitalization is used when a client deescalates or becomes a threat to self or others, not to prevent relapse. Institutionalization is not a measure to prevent relapse. Prior to the 1950s, when psychoactive drugs were introduced, many clients were institutionalized when symptoms of the illness could not be managed. Electroconvulsive therapy is offered mostly to clients with mood-disorders.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Psychosocial Integrity

19. **The nurse is developing a family-centered care plan for a client with schizophrenia. Which of the following is the priority diagnosis for the family?**
    a. Risk for caregiver role strain
    b. Knowledge deficit
    c. Activity intolerance
    d. Potential for noncompliance

Grade: 0
User Responses: d.Potential for noncompliance
Feedback: a.Rationale: Individuals and families caring for family members with a chronic disease like schizophrenia are at risk for a variety of physical and emotional problems related to caregiver role strain. Activity intolerance is an actual or potential problem for an individual and not a priority problem for a family relative to having a client with schizophrenia. Knowledge deficit would be relative to promoting compliance and preventing a client's relapse. Noncompliance is directly related to an actual or potential problem for the client.
Cognitive Level: Synthesis
Nursing Process: Planning
Client Need: Psychosocial Integrity

20. **The nurse is explaining to a student that the importance of including family members in discharge planning is to:**

(Select all that apply.)
a. Put them in contact with community resources.
b. Provide an opportunity to ask questions and discuss concerns.
c. Provide information about support groups.
d. Enable them to review the client's medical record.
e. Ensure they understand the client's needs for follow-up care.

Grade: 0
User Responses: e.Ensure they understand the client's needs for follow-up care.
Feedback: a.Rationales: Cognitive Level: Synthesis
Nursing Process: Planning
Client Need: Safe, Effective Care Environment

- Ensure they understand the client's needs for follow-up care. Family involvement in the discharge planning is important to ensure continuity of care for the client after discharge.
- Provide information about support groups. Family involvement in the discharge planning should include information about support groups to ensure continuity of care for the client after discharge.
- Provide an opportunity to ask questions and discuss concerns. Family involvement in the discharge planning should allow the family an opportunity to ask questions and discuss concerns.
- Put them in contact with community resources. Family involvement in the discharge planning should include placing them in contact with community resources to ensure continuity of care for the client after discharge.
- Enable them to review the client's medical record. Family members do not review the client's medical record as part of discharge planning.

21. **The nurse is developing a plan of care to support the family of a client with schizophrenia. Which of the following observations will assist the nurse in identifying family roles and functions?**
    a. Encourage family members to describe their role in providing care for the family member.
    b. Ask the client to describe how the family communicates.
    c. Observe communication patterns during the family meeting.
    d. Integrate data from the family communication pattern questionnaire.

    Grade: 0
    User Responses: d.Integrate data from the family communication pattern questionnaire.
    Feedback: a.Rationale: Observing communication patterns among the family provides the nurse with data to develop a plan of care. Describing their roles relative to the client's care and using data obtained from a questionnaire are not the same as the nurse observing family interactions. Gathering information from the client does not provide the nurse with an opportunity to observe family interactions.
    Cognitive Level: Synthesis
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

22. **When planning care for a client with schizophrenia, the nurse establishes goals that are:**
    a. Concise and inflexible.
    b. Challenging.
    c. Flexible and attainable.
    d. Specific and abstract.

    Grade: 0
    User Responses: d.Specific and abstract.
    Feedback: a.Rationale: The nurse establishes goals that are flexible and attainable. Goals should be specific, but need to be concrete, and should not be abstract. Goals should be concise, but need to be flexible.
    Cognitive Level: Synthesis
    Nursing Process: Planning
    Client Need: Safe, Effective Care Environment

23. **Nursing interventions to promote positive psychological behaviors when planning care for the client with schizophrenia would not include:**
    a. Focusing on the needs of the client.
    b. Encouraging client functioning.
    c. Discussing issues from perspective of the client.
    d. Minimizing small successes.

Grade: 1
User Responses: d.Minimizing small successes.
Feedback: a.Rationale: The nurse should acknowledge any success obtained by the client, even small ones. Acknowledging (rather than minimizing) even partial behavior changes as a success serves to promote self-confidence and minimize feelings of inferiority. Nursing interventions are most effective when they focus on the needs and wants of the client. Nurses encourage the client to function at his/her optimal level. It is important to understand the client's perspective in order to enhance the therapeutic relationship between client and nurse.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Psychosocial Integrity

24. **Which job would the nurse recommend to a client with paranoid schizophrenia?**
a. Working as a valet at the airport.
b. Working in the baggage claims section at the bus terminal.
c. Working as a cashier in a grocery store.
d. Working as a sorter in a packing department.

Grade: 1
User Responses: d.Working as a sorter in a packing department.
Feedback: a.Rationale: The most suitable job would be working as a sorter in a packing department as repetitive skills and minimal decision-making are involved. Working as a valet, cashier, or in a baggage claims section requires interacting with a variety of people and problem-solving which may be overwhelming for the client, leading to an increase in paranoid thinking.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Psychosocial Integrity

Chapter 16 Pre Test

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Activity Name: Chapter 16 Pre Test

1. b. “People with schizophrenia inherit a genetic predisposition to the disease rather than the disease itself.”
2. c. Dopamine.
3. b. Environmental
4. d. Hallucinations.
5. c. Anhedonia.
6. c. Alogia
7. a. Disorganized schizophrenia.”
8. b. Paranoid
9. b. Nutrition, imbalanced and c.Mobility, impaired and e.Injury, risk for
10. d. Enlist additional staff to assist, if needed.
11. d. Disturbed thought processes
12. a. “The medicine will cure his symptoms.”
13. c. Demonstrates decreased self-awareness
14. d. Inform the client that he will not be permitted to have supper if he doesn’t go to group.
15. a. In-service staff on behaviors associated with thought disorders.
16. c. Providing illness education and support
17. d. Intervening when prodromal symptoms occur.
18. b. Cognitive-behavioral therapy.
19. a. Risk for caregiver role strain
20. e. Ensure they understand the client’s needs for follow-up care. and c.Provide information about support groups. and b.Provide an opportunity to ask questions and discuss concerns. and a.Put them in contact with community resources.
21. c. Observe communication patterns during the family meeting.
22. c. Flexible and attainable.
23. d. Minimizing small successes.
24. d. Working as a sorter in a packing department.